MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW

# APPLICATION FOR BENEFITS

| Date | Our Policyholder | Accident Date | File Number |
|---|---|---|---|
| | | | |

The no-fault law provides benefits for medical expenses, wage loss and replacement services, as well as survivors' loss. To enable us to determine if you are entitled to any of these benefits, please complete this application form and return it promptly.

IMPORTANT -- TO BE ELIGIBLE FOR BENEFITS, YOU MUST:

(1) Complete, sign & return this application no later than one (1) year from the date of the accident.

(2) Submit bills for expenses promptly, but no later than one (1) year from the date the expense was incurred.

(3) Sign the attached authorization(s).

| Applicant's Name | Home Phone | Business Phone |
|---|---|---|
| | | |

| Address (No., Street, City or Town, State, Zip) | Birthdate | Soc. Sec. No. |
|---|---|---|
| | | |

| Date & Time of Accident | Place of Accident (Street, City or Town, State) |
|---|---|
| am / pm | |

Brief Description of Accident:

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Describe motor vehicles owned by you, your spouse, or relatives of either you or your spouse residing in the same household on the day of the accident:

| Vehicle | Lic. Plate No. | Owner | Insurer | Policy No. |
|---|---|---|---|---|
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☐ Check here if there are no vehicles in the household.

Describe the injury which resulted from this accident:

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(see reverse side)

Were you treated by a doctor? Name, Address & Phone of doctor(s) providing treatment:

☐ Yes ☐ No

If treated in a hospital, were you

☐ In-patient ☐ Out-patient ?

Hospital Name and Address

Do you expect to have more medical treatment? ☐ Yes ☐ No ☐ Undetermined

Have you received any benefits under a medical plan or health insurance? ☐ Yes ☐ No

Name of your medical plan, ins. company, govt. program or HMO:

Name

Address

City State Zip

Policy or plan number:

Identification No.

( ) Telephone No.

Have you received any medical treatment for the same or similar symptoms prior to this accident?

☐ Yes ☐ No

If yes, list name, address & phone of physician(s) providing treatment:

wage loss

Were you on the job working when the accident occurred? ☐ Yes ☐ No

| Date Disability from Work Began | Date Returned or Anticipate Returning to Work | Avg. Weekly Wage/Salary |
|---|---|---|
| | | |

Have you received any benefits under workers' compensation, social security, or any wage or salary continuation plan? ☐ Yes ☐ No

If yes, indicate source of payment: _____

Amount of payment per month: _____ Per Week: _____

Are you currently receiving unemployment benefits? ☐ Yes ☐ No

List names, addresses & phones of present employer(s):

Name, address & phone Occupation Date Hired

Name, address & phone Occupation Date Hired

exp.

As a result of your injury, have you incurred any other expenses, such as transportation costs or expenses for services you would have performed for yourself or your dependents? ☐ Yes ☐ No If yes, explain on a separate sheet and attach.

These statements are true and complete to the best of my knowledge:

_____ Date: _____

Signature of applicant or parent or guardian